

# APPLICATION FOR ENTITY PROFESSIONAL LIABILITY INSURANCE COVERAGE



**OPHTHALMIC MUTUAL  
INSURANCE COMPANY**  
(A Risk Retention Group)

655 Beach Street  
San Francisco CA 94109-1336

P.O. Box 880610  
San Francisco CA 94188-0610

Phone: (800) 562-6642, ext. 639  
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Email: omic@omic.com  
Web site: www.omic.com

**The policy to which this application applies is issued by Ophthalmic Mutual Insurance Company (A Risk Retention Group). Risk retention groups may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.**

No coverage exists until Declarations listing you as an insured are issued.

**This application does not apply to outpatient surgical facilities or medical spas. If this entity is a surgery center or refractive surgery center, please complete a Supplemental Outpatient Surgical Facility Questionnaire. If this is a medical spa, please complete a Supplemental Medical Spa Questionnaire. You may download the required questionnaire from OMIC's web site, [www.omic.com](http://www.omic.com), or contact an underwriting representative.**

Please PRINT or TYPE your answers and personally sign and date the warranty, authorization, membership agreement, disclosure form, and prior claims information supplement. Signature stamps are not acceptable.

**Please answer all questions COMPLETELY, including any additional comments required, since incomplete information may delay processing.** If a question does not apply, use N/A.

**1** Entity's legal name: \_\_\_\_\_

**2** **A.** Other name(s) under which you currently do business: \_\_\_\_\_

**B.** Other name(s) used in the past: \_\_\_\_\_

**3** Contact person's name: \_\_\_\_\_ Title: \_\_\_\_\_

**4** **A.** Primary Office Address: \_\_\_\_\_

\_\_\_\_\_

City State County Zip code

**B.** Office Phone: ( ) \_\_\_\_\_ **C.** Fax: ( ) \_\_\_\_\_ **D.** Email: \_\_\_\_\_

**E.** Mailing Address (if different from above): \_\_\_\_\_

\_\_\_\_\_

City State County Zip code

**F.** Billing Address: Same as  Primary Office  Mailing  Other listed below

\_\_\_\_\_

City State County Zip code

**5** Date of incorporation/establishment: \_\_\_\_\_ **6** Federal Tax ID: \_\_\_\_\_

**7** Describe the nature of your business operations: \_\_\_\_\_

**8** Please indicate the county(ies)/state(s) in which you are located and the number of office locations in each.

County	State	No. of Locations
_____	_____	_____
_____	_____	_____
_____	_____	_____

**9** How is the practice organized? (Please check one.)

- Partnership
  Multi-shareholder Corporation
  Sole Shareholder Corporation  
 Limited Liability Partnership
  Limited Liability Corporation

10 Practice affiliation is:  Ophthalmology-exclusive  Multispecialty

11 Please list all of the physician members of the practice and the status of each. Continue on a separate page if there are additional practice affiliates. **If any members are not insured by OMIC, submit a copy of the Declarations page from their current policy and a "loss history"/"claims experience" report:**

Status Codes: O-Owner; E-Employee; I-Independent Contractor

Name	Status	Name	Status
A. _____	_____	D. _____	_____
B. _____	_____	E. _____	_____
C. _____	_____	F. _____	_____

12 Are there any non-physician owners?  Yes  No

If yes, please list their name, professional designation, and percentage of ownership.

Name	Professional Designation	Percentage of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

13 Do you own or operate a separately incorporated optical shop?  Yes  No

If yes, do you maintain separate insurance (general liability with professional liability) for your optical shop?  Yes  No

14 Do you operate an outpatient surgical facility (i.e., a surgery center, refractive surgery center, or allow other physicians to use your in-office surgical suite)?  Yes  No

Would you like OMIC to also insure your outpatient surgical facility?  Yes  No

If yes, a **Supplemental Outpatient Surgical Facility Questionnaire** will be forwarded to you for completion, or you may download the questionnaire from OMIC's web site at [www.omic.com](http://www.omic.com).

15 Do you own or operate a medical spa?  Yes  No

If yes, a **Supplemental Medi-Spa Questionnaire** will be forwarded to you for completion, or you may download the questionnaire from OMIC's web site at [www.omic.com](http://www.omic.com).

16 A. Please specify the number of anesthesiologists and allied health professionals you employ or contract with:

<input type="checkbox"/> None - OR -	Category	Employed	Contracted
	Aestheticians	_____	_____
	Physician's Assistants (PA)	_____	_____
	Nurse Practitioners (NP)	_____	_____
	Optometrists (OD)	_____	_____
	Nurse Anesthetists (CRNA)	_____	_____
	Anesthesiologists	_____	_____

B. For each employee or contractor noted above, submit a copy of the Declarations page from their current policy.

C. Would you like to insure your employed aesthetician(s), PA(s), NP(s), OD(s), or CRNA(s) as additional insureds under your policy?  Yes  No

If yes, the required applications (if applicable) will be forwarded to you for completion. Applications are also available on OMIC's web site at [www.omic.com](http://www.omic.com).

17 Please attach a copy of your office letterhead.

**18** What form(s) of advertising (*other than a general yellow pages listing*) do you use? Please check all that apply.  
 None       Mass Mailings       Print       Radio       Television       Billboard  
 Internet (*provide web site address*): \_\_\_\_\_

**Submit copies of all advertising currently used.**

**19** Has any medical professional liability insurer canceled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions, or have you ever withdrawn your application for coverage or voluntarily canceled due to unfavorable underwriting review?  Yes  No

**If yes**, please specify the action taken and reason for such action. Also submit a copy of any correspondence between you and the carrier concerning this action.

**20** Has a fee complaint or professional conduct complaint ever been registered against the entity, its physician associates, or non-physician employees?  Yes  No

**If yes**, please provide a copy of the complaint, your response, and, if resolved, the final resolution. For professional conduct complaints, also submit copies of the patient charts and operative notes.

**21 A.** Have **any** professional liability or premises liability claims or suits **ever** been brought against the entity or its non-physician employees (*regardless of merit*)?  Yes, Number: \_\_\_\_\_  No

**B.** Have you ever reported any other incidents or potential claims to your present or previous carriers?  Yes, Number: \_\_\_\_\_  No

**C.** Are you aware of **any** facts or circumstances that may give rise to a claim or suit in the future?  Yes  No

**If you answered "yes" to any of the above**, please complete a **Prior Claims Information Supplement** for each circumstance. For more than one incident or claim, please use photocopies of the form.

**D.** With your application, please submit a "loss history"/"claims experience" report **provided by your insurance carrier** indicating your reportable claims history.

**22** List the names of all professional liability insurance carriers that have insured you during the past five years and the dates of such coverage. (*Continue on the **Comments page**, if necessary.*)

**A.** Carrier: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_

**B.** Carrier: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_

**23** **Attach a copy of the Declarations Page(s) and all applicable Endorsements from your current policy.**

**24** What is your requested effective date of coverage? \_\_\_\_\_  
(*Please note that your actual policy effective date may be different, subject to OMIC's underwriting rules.*)

**25** Is your current coverage on a  claims made or  occurrence basis?

**If claims made:**

**A.** What is your retroactive date? \_\_\_\_\_

**B.** Do you wish to buy prior acts coverage from OMIC to insure you for new, unreported claims arising from services you provided while you were insured with your present carrier?  Yes  No

**C. If no**, do you intend to purchase extended reporting endorsement ("tail") coverage from your present carrier?  Yes  No

**26** Check the limits of liability you would like. We will provide quotations for more than one limit if requested.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> \$100,000/\$300,000* | <input type="checkbox"/> \$500,000/\$1,000,000*  | <input type="checkbox"/> \$2,000,000/\$4,000,000         |
| <input type="checkbox"/> \$200,000/\$600,000* | <input type="checkbox"/> \$500,000/\$1,500,000   | <input type="checkbox"/> \$5,000,000/\$10,000,000        |
| <input type="checkbox"/> \$250,000/\$750,000* | <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> Other ( <i>specify</i> : _____) |

\* Available only in states with Patient Compensation Funds

The entity's liability limits can be no higher than the limits carried by its physician members.

Sole shareholder corporations generally share liability limits with the owner ophthalmologist.

Do you desire separate liability limits for your sole shareholder corporation?  N/A  Yes  No

## HIPAA DISCLOSURE

Under the HIPAA Privacy Regulations, you may disclose protected health information (PHI) without patient authorization to medical professional liability insurers in order to obtain or maintain insurance coverage. OMIC will (1) maintain the confidentiality of PHI you provide to us, (2) use it only for the purposes for which it was disclosed, and (3) notify you of any breach of confidentiality of PHI. If OMIC insures you, OMIC will become your business associate and will safeguard PHI in accordance with OMIC's Business Associate Agreement.

## ARBITRATION CLAUSE

The OMIC professional and limited office premises liability policy contains an Arbitration Clause. By accepting the policy coverage, you will be bound by the terms of the Arbitration Clause. This Clause states that any dispute you have with OMIC arising out of the policy must be submitted exclusively to final and binding arbitration. Under the Clause, you agree not to proceed against OMIC in state or federal court and specifically acknowledge waiving your right to a jury trial. Any arbitration award rendered will be final and not subject to appeal. Arbitration will take place in any jurisdiction that is convenient to you and agreed to by the parties. Each party pays its own arbitration costs and the fees of its selected arbitrator and they share equally in the fees of the neutral arbitrator and any other arbitration costs. You must keep confidential the nature of the arbitration proceeding and the award.

## WARRANTY AND ACCEPTANCE OF POLICY TERMS

I understand that for purposes of obtaining, retaining, and modifying insurance coverage all statements contained in this application and all required supplemental questionnaires are considered material to the issuance of coverage. I warrant that the information furnished as a part of this application is true to the best of my knowledge and is furnished in good faith. I further warrant that I have not withheld information that is likely to influence the judgment of OMIC in evaluating this application.

**I agree to update this application while it is pending should there be any change in the information provided that may affect the application or its outcome, and to update such information if and after OMIC extends insurance coverage.**

I understand that failure to supply requested information on a timely basis, falsification or omission of information requested, or failure to update such information during the entity's term of coverage may result in a declination or termination of coverage or denial of coverage for a claim based on the omitted, false, or undisclosed information.

I understand that this application and any other application(s), supplemental questionnaire(s), and any other document(s) submitted to OMIC for the purpose of obtaining, retaining, or modifying insurance coverage with OMIC, together with the policy, the Declarations, and any endorsements, will constitute the contract of insurance between OMIC and the entity.

I acknowledge that as part of the ongoing underwriting review of the entity's insurance coverage with OMIC, certain information pertaining to any open or closed claim made under the entity's OMIC policy may be reviewed in determining whether coverage may be continued, and I consent to the communication of summary information between the claims and underwriting departments.

I understand that coverage does not become effective until this application is approved, the required premium for the insurance has been paid, and Declarations listing the entity as an insured are issued.

I understand that the entity will become a member and insured of OMIC if this application is approved and the entity pays the required insurance premium, and the entity will then be bound by the terms of the insurance policy issued it. I have read the policy included in the application materials carefully to determine the entity's rights and duties. I understand that I should discuss the coverage with my attorney, insurance advisor, or risk management consultant. By my signing this application as the entity's authorized representative, the entity agrees to be bound by the terms, conditions, exclusions, restrictions, and definitions of the OMIC professional and limited office premises liability insurance policy.

\_\_\_\_\_  
*Signature of Authorized Representative (Do not use signature stamp.)*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Authorized Representative's Name (Please print.)*

\_\_\_\_\_  
*Date*

## AUTHORIZATION TO RELEASE INFORMATION

I consent to the communication of information and documents between OMIC and other insurance companies, hospitals, teaching institutions, professional associations, licensing agencies, and other persons who may have information pertaining to this application, the entity's qualifications for insurance, or claims under review.

I release from liability, to the fullest extent allowed by law, OMIC and its agents and representatives for their acts performed in connection with evaluating this application, the entity's qualifications for insurance, or claims under review.

I release from liability, to the fullest extent allowed by law, all individuals and organizations who provide information and documents to OMIC or its agents or representatives concerning this application, the entity's qualifications for insurance, or claims under review.

\_\_\_\_\_  
*Signature of Authorized Representative (Do not use signature stamp.)*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Authorized Representative's Name (Please print.)*

\_\_\_\_\_  
*Date*

## MEMBERSHIP APPLICATION AND AGREEMENT—MEDICAL ENTITY

For and in consideration of the benefits to be derived therefrom, the Applicant hereby applies for membership in the Ophthalmic Mutual Insurance Company (a Risk Retention Group) ("OMIC"), the principal office being located at 126 College Street, Suite 400, Burlington, Vermont 05401; and the main business office being located at 655 Beach Street, San Francisco, California 94109-1336.

The Applicant hereby acknowledges that:

- 1** The undersigned medical professional entity, hereafter referred to as "the Applicant," represents and warrants that the entity's ownership or control consists of at least 50% of ophthalmologists who are licensed to practice medicine in each state where they practice and who are members of the American Academy of Ophthalmology.
- 2** The Applicant understands that this membership is subject to acceptance by OMIC.
- 3** Membership begins with the commencement of the policy period of a claims made and reported insurance policy issued by OMIC, and ends upon the cancellation or other termination of that policy. The period of membership shall not include any period of coverage under extended reporting or tail coverage endorsements. After termination of membership, the member shall have no further right to participate in any distribution of savings to members or in any distribution of assets upon the dissolution of OMIC, except for amounts that may be due to the member for loans or surplus contributions under separate instruments issued by OMIC.
- 4** The Applicant, through its authorized representative, has read the Bylaws of OMIC and agrees that if the entity's application for insurance is accepted by OMIC, the Applicant shall at such time become a member of OMIC. Membership shall, among other things, evidence ownership in OMIC to the extent required by Vermont law governing mutual insurance companies and risk retention groups. As a member of OMIC, the Applicant will be bound by the terms and conditions of the Bylaws of OMIC, as such may be amended from time to time.

\_\_\_\_\_  
*Signature of Authorized Representative (Do not use signature stamp.)*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Authorized Representative's Name (Please print.)*

\_\_\_\_\_  
*Date*

## DISCLOSURE FORM: CLAIMS MADE AND REPORTED POLICY

### IMPORTANT NOTICE TO INSURED

**THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT MERELY DESCRIBES SOME OF THE MAJOR FEATURES OF OMIC'S CLAIMS MADE AND REPORTED POLICY. READ YOUR POLICY CAREFULLY TO DETERMINE YOUR RIGHTS AND DUTIES AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.**

Your policy is a claims made and reported policy. It applies only to claims made against you and reported to OMIC after the inception date and within five days after the end of the policy period arising from professional services incidents that occur on or after the policy retroactive date. Upon termination of your policy, an extended reporting period may be available.

## OCURRENCE VS. CLAIMS MADE AND REPORTED

“Occurrence” and “claims made and reported” policies generally cover the same kinds of professional services incidents. However, claims for damages may be assigned to different policy periods depending on which policy you have.

In an “occurrence” policy, coverage is provided for liability because of professional services incidents that *occur during the policy period, no matter when the claim is made.*

In your “claims made and reported” policy, coverage is provided for liability because of professional services incidents *if the claim is first made against you and reported to OMIC during the policy period or within five days after the end of the policy period.* The claim must be a written notice or demand that you have received arising from an act, error, or omission in the provision of services. A claim is considered made when it is received by you and reported when it is received by us. A claim may be assigned to an earlier policy period if, for example, another claim based on the same professional services incident has already been made during the earlier policy period.

## PRINCIPAL BENEFITS, CONDITIONS, EXCLUSIONS, AND RESTRICTIONS

The policy provides coverage for professional and limited office premises liability up to the maximum dollar limit specified in the policy and the policy Declarations. The principal benefits and coverages are explained in detail in your claims made and reported policy. The policy also contains certain conditions, exclusions, and restrictions. Please read your policy carefully and consult your attorney, insurance advisor, or risk management consultant for any questions you might have.

## RENEWALS, RETROACTIVE DATES, AND EXTENDED REPORTING PERIODS

Your claims made and reported policy has some unique features relating to renewal, coverage of incidents with long periods of exposure, and extended reporting periods. These special provisions are described below.

### Renewal

Your premium may increase or decrease upon renewal. You will receive notification in accordance with the terms of your policy.

### Retroactive Date

When you have a retroactive date entered on the Declarations page, there is no coverage for professional services incidents that occur before the retroactive date, even if the claim is first made and reported during the policy period. If there is no retroactive date entered on the Declarations page, the policy will respond to claims first made during the policy period or within five days after the end of the policy period for covered professional services incident, no matter when the incident occurred.

If there is a retroactive date, it cannot be moved ahead in time except with your written consent and only under certain circumstances, including the following: you have changed insurers; there is a substantial change in your operations that increases your exposure to loss; or you have failed to provide us with information about the nature of your business or premises. It is important to understand how the claims made and reported policy's extended reporting period guarantees continuity of coverage if you are offered a renewal or replacement policy with a later retroactive date than the one in your current policy.

### Extended Reporting Periods or “Tails”

**If a claim is made and reported more than five days after the termination of your claims made and reported policy, you may not have coverage for that claim.** Insured ophthalmologists, slots, and professional entity Policyholders may purchase an extended reporting period or “tail” endorsement, which will be offered with at least the aggregate limit of the Insured's terminated policy and will allow reporting for at least one year after the end of the policy. Carefully review the policy provisions regarding the available extended reporting period and the time during which you must purchase or accept any offered extended reporting period endorsement.

If the coverage under this policy of any Insured non-physician employee or locum tenens terminates, he or she will continue to be covered for claims based on incidents that occurred while the employee or locum tenens was employed by the Insured ophthalmologist or professional entity, even if the claim is not reported until after the employee or locum tenens is no longer employed, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the employer Insured. Limits of liability for the claim will be shared with the employer Insured.

If the coverage under this policy of any Insured professional entity that shares limits with another Insured terminates by reason of the dissolution or other termination of activity of the professional entity, the professional entity will continue to be covered for claims based on incidents that occurred while such professional entity was active, even if any such claim is not reported until after the professional entity ceases activity, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the Insured with which the professional entity shares limits.

\_\_\_\_\_  
Entity Name

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name and title

## PRIOR CLAIMS INFORMATION SUPPLEMENT

Complete one form for each incident, claim, or suit. If you need additional space, please attach a separate page. Copy this form if more than one claim is being reported. Please type.

1 Name of Applicant: \_\_\_\_\_

2 Name of Patient/Claimant: \_\_\_\_\_

3 Date(s) of Treatment: \_\_\_\_\_ Date of Claim/Suit: \_\_\_\_\_

4 Claimant's Allegation: \_\_\_\_\_

5 Name of Insurance Carrier Providing Defense: \_\_\_\_\_

6 Additional Defendants: \_\_\_\_\_

7 Status:  Incident (*reported to carrier on a precautionary basis only; oral allegation or demand made*)  
 Claim (*written demand made; notice of intent received; or other cases classified by your carrier as a claim*)  
 Suit (*summons and complaint served*)

8 Chronologic summary of events (*including nature of treatment and your involvement*). Your chronological summary of events should provide sufficient detail from which OMIC can make an independent assessment of the care rendered.  
**If case is still pending or indemnity has been paid, attach copies of patient charts and operative notes.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*(Continue on the **Comments page**, if necessary. Be sure to sign and date any additional pages.)*

9 Disposition of Claim:  
 Open **If open**, has the carrier indicated a desire to settle?  Yes  No  
 Closed Amount of Settlement/Judgment \$ \_\_\_\_\_ Date closed: \_\_\_\_\_

**NOTE: This policy will not apply to any claim arising out of any professional services incident occurring prior to the effective date of the first policy issued to the applicant and continuously renewed thereafter if the applicant was aware of or could have reasonably known at the time of application that a claim or suit could develop from that incident.**

"I understand that information submitted herein becomes part of the Application for Entity Professional Liability Insurance Coverage."

\_\_\_\_\_  
*Signature of Authorized Representative (Do not use signature stamp.)*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Authorized Representative's Name (Please print.)*

\_\_\_\_\_  
*Date*

